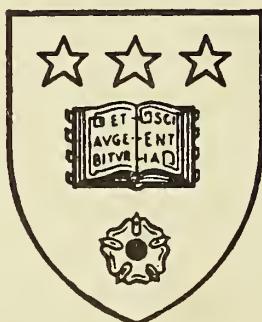
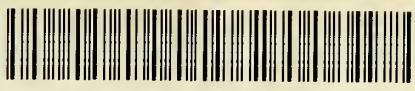


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PORTFOLIO
OF
DERMOCHROMES

BY *Eduard*
PROFESSOR JACOBI
Of Freiburg im Breisgau.

English Adaptation of Text
BY
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Physician to the Department for Diseases of the Skin at the
Middlesex Hospital, London.

SUPPLEMENT

CONTAINING 76 ADDITIONAL COLOURED ILLUSTRATIONS



LONDON:
REBMAN LIMITED,
129, Shaftesbury Avenue, W.C.

1906.

NEW YORK:
REBMAN COMPANY,
1123 Broadway.

Published the 5th day of March, 1906.

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Preface

THE publication of a Supplement to Professor Jacobi's work has been prompted principally by the urgent request of numerous professional friends to fill in certain lacunæ in the existing work, so as to render it a practically complete pictorial Atlas of Diseases of the Skin.

To these friends Professor Jacobi desires to express his indebtedness. The Supplement contains seventy-six new dermochromes, many of which depict syphilitic manifestations, the importance of which is universally admitted. But several non-syphilitic diseases not hitherto illustrated are also included, some of which—*e.g.*, Darier's disease, *Myiasis linearis*—are regarded in most text-books as extreme rarities. This opinion Professor Jacobi does not share, and the translator endorses the author's view.

Numerous types or phases of common skin affections not delineated in the work have also been added, and cannot fail to conduce to its increased practical utility both to the student and practitioner.

Especial thanks must again be expressed to Professor Neisser of Breslau, who has placed his entire wealth of material at the author's disposal. A deep debt of gratitude is also due to Professor

von Bergmann, Professor Lassar, Dr. Max Joseph, Dr. Buschke. Dr. Heubner, and Professor Greef, of Berlin ; to Professor Schlossmann and Dr. Werther of Dresden ; to Dr. Henning and Professor Finger of Vienna ; to Professor Pospelow of Moscow ; and to Professors Fournier and Jullien of Paris, all of whom have permitted models in their possession to be utilized. Due recognition must also be acknowledged to the kindly and energetic assistance of Professor Jacobi's former assistant, Dr. von Linck, and to Messrs. Baretta, Jumelin, Kolbow, Kröner, Kasten, Fiweisky, and Johnsen, who are responsible for the models from which the dermochromes have been executed under the direct and special supervision of Dr. Albert of Munich, with whom rests the credit of first devising and carrying out the method of delineation employed throughout the work with such brilliant success and gratifying results.

J. J. PRINGLE.

LONDON, 1906.

A very faint, large watermark-like image of a classical building with four prominent columns is visible in the background.

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Purpura Hæmorrhagica.

SUPPLEMENT, PLATE I., FIG. 158.

For Text, see Vol. I., pages 5 and 6.

Fig. 158. Model in Neisser's Clinic in Breslau (Kröner). A number of bullæ with slightly hæmorrhagic margins are present in addition to the usual purpuric spots.

Herpes Progenitalis.

SUPPLEMENT, PLATE I., FIG. 159.

For Text, see Vol. I., pages 75 and 76.

Fig. 159. Model in Saint Louis Hospital in Paris, No. 1923
(Baretta). Fournier's case.



159. Herpes progenitalis.



158. Purpura haemorrhagica.

Lupus Erythematosus Disseminatus.

SUPPLEMENT, PLATE II., FIG. 160.

For Text, see Vol. I., page 14 *et seq.*

Fig. 160. Model in Freiburg Dermatological Clinic (Johnsen).

The superficial invasion of the skin of the cheeks permits the recognition of the existence of numerous small circular lesions, especially in the marginal portions of the disease. Under internal treatment with quinine and painting with iodine the affection was soon reduced to minimal proportions.

Lupus Pernio.

Chilblain Lupus.

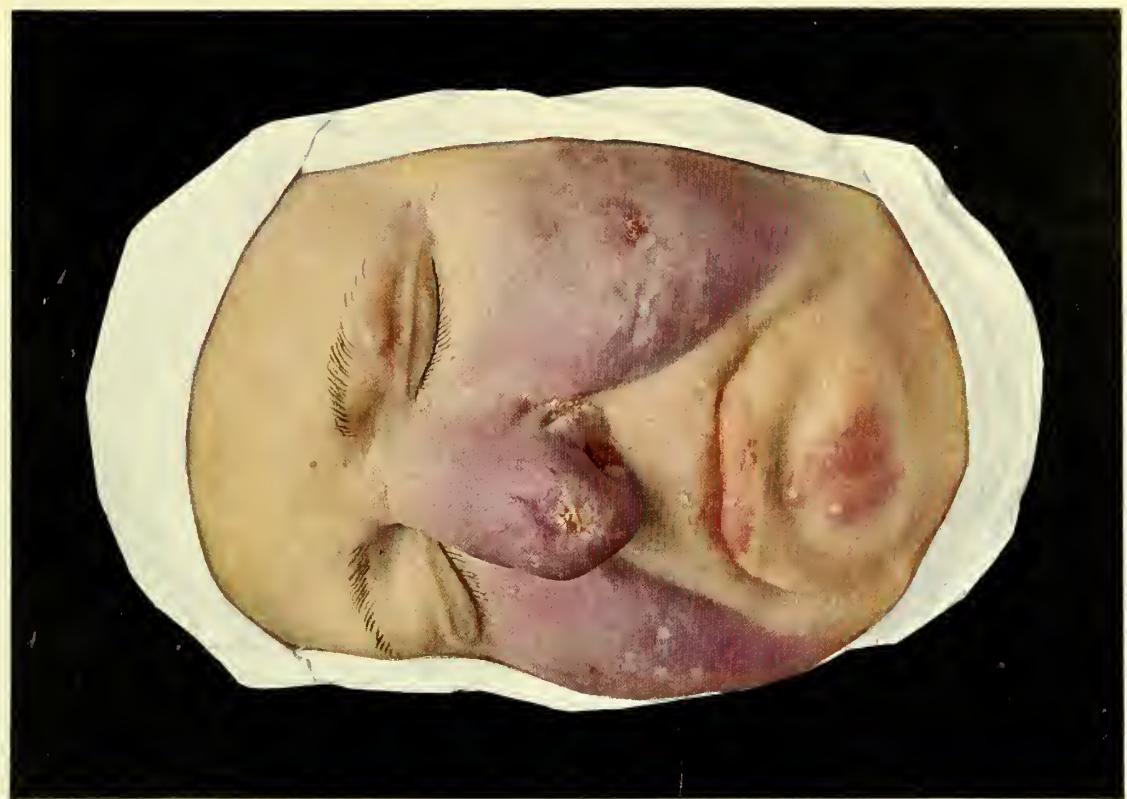
SUPPLEMENT, PLATE II., FIG. 161.

Lupus pernio is a rare disease, the relationships of which to Lupus vulgaris and Lupus erythematosus are not yet clearly defined. It is characterized by the development of large cyanotic, ill-defined infiltrations and swellings, more especially on the uncovered skin of the face, ears, and hands. Small excoriations and ulcers may form in some spots, which heal up very slowly after scabbing, leaving scars. The malady, which generally occurs in anaemic persons, may recover spontaneously even after lasting for years.

The **Differential Diagnosis** must be especially established from chilblains. These latter, however, are smaller in size, and disappear with the advent of warm weather.

Treatment.—No certain method of curing Lupus pernio is known. It is advisable to combat anaemia with iron and arsenic. For the ulcerative forms moist dressings may be used; but if the epidermis is intact, warm baths, massage, and mild plasters are suitable.

Fig. 161. Model in Saint Louis Hospital in Paris, No. 1694 (Baretta). Tenneson's case.



161. Lupus pernio (Chilblain Lupus).



160. Lupus erythematosus disseminatus.

Lupus Vulgaris Incipiens.

Early Lupus Vulgaris.

SUPPLEMENT, PLATE III., FIG. 162.

For Text, see Vol. I., page 17 *et seq.*

Fig. 162. Model in Freiburg Dermatological Clinic (Johnsen).

Lupus Vulgaris Verrucosus.

Warty Lupus Vulgaris.

SUPPLEMENT, PLATE III., FIG. 163.

For Text, see Vol. I., page 17 *et seq.*

Fig. 163. Model in Freiburg Dermatological Clinic (Johnsen).



163. Lupus vulgaris verrucosus.



162. Lupus vulgaris incipiens.

Tuberculosis Linguæ. Tuberculosis Nasi.

Tuberculosis of Tongue and Nose.

SUPPLEMENT, PLATE IV., FIGS. 164, 165.

In persons who suffer from tuberculosis of internal organs, true tuberculosis of the skin and mucous membrane, especially at their points of junction, is observed much less frequently than ordinary lupus. But—generally as the result of direct infection by bacilli in the discharge—ulcers may form which are round or irregular in shape, painful, and extend rapidly; their base is granular, bleeds easily, and is partly covered with sticky discharge, while miliary tubercular nodules may not unfrequently be identified at their margins (Fig. 165). On mucous membrane the margins are, as a rule, undermined (Fig. 164). Numerous bacilli are—in contradistinction to lupus—to be found in the ulcers, which have also a much slighter tendency to heal, extend with far greater rapidity, but seldom attain larger dimensions than in lupus, as the patients die sooner.

The **Diagnosis** can generally be established without difficulty on the grounds of their localization, characteristic appearance, painfulness, and the general tubercular symptoms. It may be confirmed by the

discovery of bacilli. The differentiation from syphilis may be established by the behaviour of the lesions under antisyphilitic treatment.

The **Prognosis** is unfavourable.

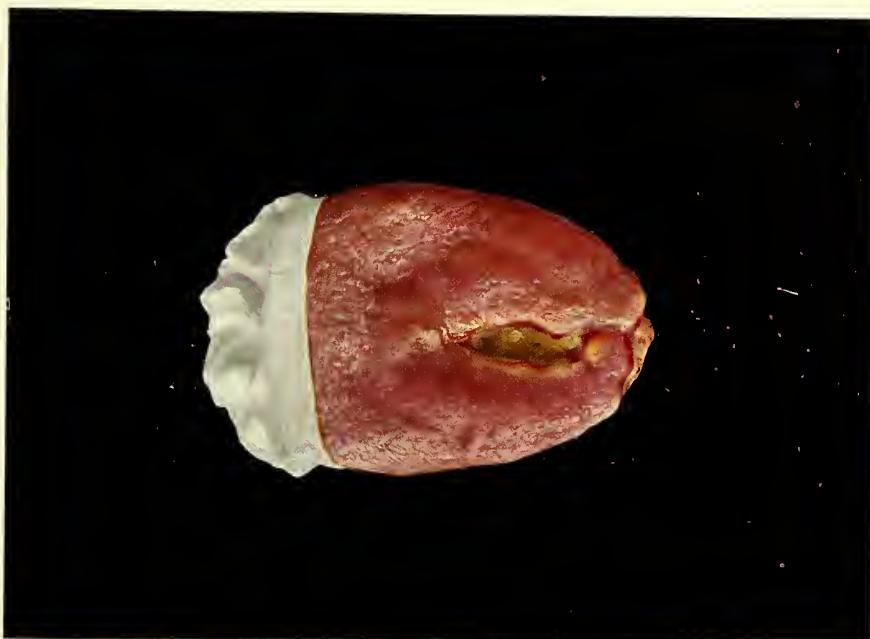
Treatment must have for its object the diminution of pain by dusting with orthoform, anaesthesin, and similar remedies, as the general condition of the patient usually forbids the use of energetic measures. Should such, however, be permissible, attempts may be made to effect a cure with caustics, 'light treatment,' or surgical measures.

Fig. 164. Model in Saint Louis Hospital in Paris, No. 1768
(Baretta). Tenneson's case.

Fig. 165. Model in Saint Louis Hospital in Paris, No. 2236
(Baretta). Hallopeau's case.



165. Tuberculosis nasi.



164. Tuberculosis linguae.

Lepra Tuberosa.

Nodular Leprosy.

SUPPLEMENT, PLATE V., FIG. 166.

For Text, see Vol. I., page 27 *et seq.*

Fig. 166. Model in Lassar's Clinic in Berlin (Kasten).

Lepra Psoriasiformis.

Squamous Leprosy.

SUPPLEMENT, PLATE V., FIG. 167.

In patients suffering from *nerve leprosy* there are often present on the extensor surfaces of the extremities brownish-red, scaly, very flat infiltrates manifesting a great resemblance to psoriatic lesions, and this is augmented by their localization. The other symptoms of nerve leprosy, which are generally present at the same time, will facilitate the **Diagnosis** in doubtful cases ; and this will be confirmed by the discovery of bacilli, which are present in most cases.

Fig. 167. Model in Neisser's Clinic in Breslau (Kröner).



167. *Lepra psoriasisiformis.*



166. *Lepra tuberosa* (Nodular Leprosy).

Psoriasis Vulgaris Capitis.

Psoriasis of the Scalp.

SUPPLEMENT, PLATE VI., FIG. 168.

For Text, see Vol. I., page 41 *et seq.*

Fig. 168. Model in Neisser's Clinic in Breslau (Kröner).

Psoriasis Vulgaris Unguium.

Psoriasis of Nails.

SUPPLEMENT, PLATE VI., FIG. 169.

When psoriasis is localized on the hands and feet, there occur, besides other changes in the nails (see Vol. I., p. 43), marked thickening of the nail substance, with opacity and separation from the nail-bed which begins at the peripheral end (Fig. 169). In severe cases the nails may even be completely shed.

Fig. 169. Model in Neisser's Clinic in Breslau (Kröner).



169. *Psoriasis vulgaris unguium.*



168. *Psoriasis vulgaris capitis.*

Exfoliatio Areata Linguae.

Geographical Tongue.

SUPPLEMENT, PLATE VII., FIG. 170.

In this disease there appear upon the tip and marginal portions of the tongue—without apparent cause—grayish - white, sometimes yellowish, round spots which extend rapidly in crescentic lines enclosing somewhat depressed, smooth areas of mucous membrane of a brighter and deeper red colour than the other parts of the tongue. The margins, which are made up of thickened epithelium, measure from $\frac{1}{2}$ to 3 millimetres in breadth, and spread in crescentic segments ; but they do not cross the middle line, and only exceptionally invade the lower aspect of the tongue. Decorative, festooned, and geographical figures result from the confluence of contiguous patches and the appearance of fresh rings in the centre. Gradually the central portions become paler and resume their normal characters ; the whitish margins disappear, and the diseased parts heal without scarring, but the process of cure may be delayed for months or even years by the occurrence of repeated exacerbations.

Subjective symptoms are usually slight, and consist of a certain amount of oversensitiveness, but sometimes severe pain is observed.

The affection occurs most frequently in children, and

recovery generally takes place at the age of four or five years. In adults the duration of the disease is unlimited. Its cause is absolutely unknown, but in some cases hereditary predisposition has been definitely established.

The **Diagnosis** is easily made by the observation of the typical, rapidly spreading rings surrounding intensely red areas of mucous membrane. Syphilitic mucous patches are not of so deep a red colour ; their epithelium, as a rule, is not dullish white at the margin only ; they are painful, often deeply eroded, and do not change their form so quickly ; finally, they disappear under antisyphilitic treatment.

Leukoplakia of the tongue exhibits a permanent picture without recent inflammatory phenomena.

The **Prognosis** is so far favourable, as the condition does not produce severe symptoms ; but the outlook is dubious as regards cure.

No effectual form of **Treatment** is known ; only temporary benefit can be attributed to the remedies recommended, which include lotions of decoctions of camomile or bilberry, solutions of boric acid, common salt, chloride of potassium, as well as caustic applications of lactic acid, chromic acid, nitrate of silver, and other similar substances.

Fig. 170. Model in Saint Louis Hospital in Paris, No. 2235 (Baretta). Meureman and Ramond's case.

Lingua Scrotalis.

SUPPLEMENT, PLATE VII., FIG. 171.

The ‘scrotal tongue’ derives its name from its resemblance to the scrotum when contracted by cold. It is a congenital and usually hereditary affection in which the mucous covering is proportionally too extensive to correspond exactly to the body of the tongue, and appears to be arranged in numerous branching longitudinal and transverse folds. Often these folds are arranged like the veins of a leaf (Fig. 171). Local irritation—*e.g.*, by the decomposition of the remains of food in the depths of the furrows—may cause some degree of local superficial inflammation, but otherwise the condition is of no consequence.

Fig. 171. Model in Freiburg Dermatological Clinic (Johnsen).

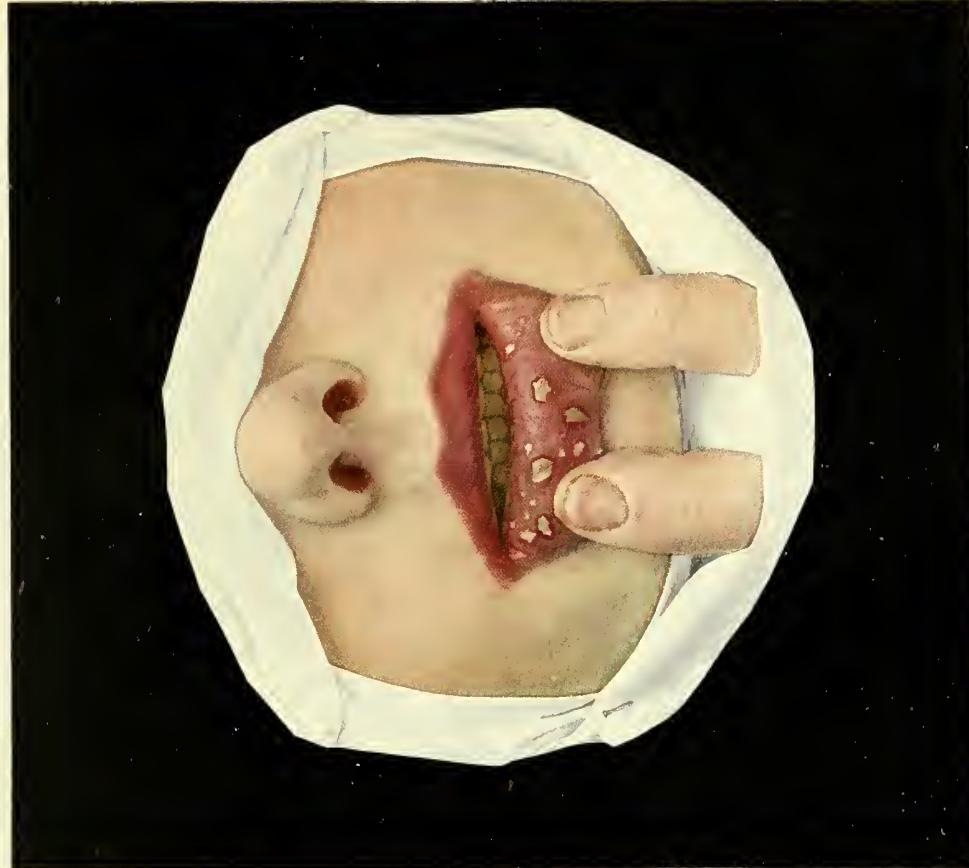
Aphthæ.

SUPPLEMENT, PLATE VII., FIG. 172.

The name Aphthæ (*Stomatitis aphthosa*) is employed to connote roundish or oval patches of whitish colour with narrow, red margins which occur in the mouth either as a subacute or acute condition, in the latter instance being accompanied by the symptoms of a general infection. They attack more especially the lips, the tongue, and the gums, but also the hard and—more rarely—the soft palate. By their confluence they may assume irregular forms, and may attain much greater dimensions. They may give rise to considerable pain, especially as the result of eating; and they heal in two or three weeks, unless repeated exacerbations occur. Analogous eruptions sometimes attack the female genital organs. Symptoms of general stomatitis are usually present in the more severely febrile cases. The disease occurs most frequently in children during teething, but cases of obstinately recurrent aphthæ are of not unfrequent occurrence in adults.

Aphthæ are very probably caused by various excretants of bacillary nature, and disturbances of digestion or decayed teeth are favourable concomitants for their operation.

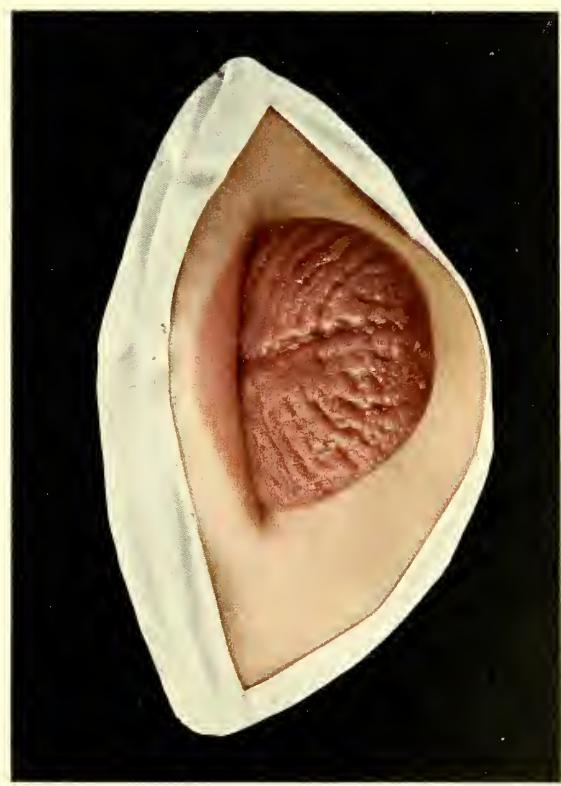
The **Diagnosis** is usually easily made by considering their acuteness of outbreak, their localization,



172. Aphthae.



170. Exfoliatio areata linguae
(Geographical Tongue).



171. Lingua scrotalis.

and their typical course. Patients who have previously suffered from syphilis have a great tendency to regard aphthæ as recurrences of their syphilitic trouble, and are often accordingly greatly distressed by them.

The **Prognosis** is generally favourable; but there is no known remedy which prevents recurrences.

The first object in **Treatment** is to order as non-irritating a dietary as possible. In cases where nutrition is interfered with by the pain of eating, this may be combated by painting with cocaine or powdering with orthoform, anæsthesin, and similar substances. Bathing the parts with camomile tea or very weak solutions of boric acid, peroxide of hydrogen, acetate of aluminium, or permanganate of potassium are also employed. Touching with concentrated solutions of nitrate of silver or with sulphate of copper may hasten the healing process.

Fig. 172. Model in Dr. Max Joseph's Polyclinic in Berlin (Kolbow).

Darier's Disease.

Psorospermosis Follicularis Vegetans.

SUPPLEMENT, PLATE VIII., FIG. 173.

Darier's disease was named by the author who first described it as '*Psorospermosis follicularis vegetans*,' although it is not due to the presence of psorosperms, nor is it connected with follicles, nor is it—in all cases—accompanied by vegetations. It is characterized by the presence of small acuminate nodules, most thickly aggregated on the face, scalp, and flexures; but they often exist also on the thorax, where they are more scattered or grouped (Fig. 173). They are at first of the normal colour of the skin, but, as they develop, assume a grayish-brown or brownish-red tint. At their summit they are covered by a conical horny plug which can be scratched off, disclosing a peg-shaped process on their under surface. These lesions are thickly packed together on the backs of the hands, where they resemble recent warts; while on the palms the prominent features are the general hyperkeratosis and the marked dilatation of the sweat ducts. Even the nails show morbid changes, especially linear stripes. The morbid picture is often complicated by the presence of seborrhœic eczema. More rarely the condition culminates in papillomatous growths of special character in





173. Darier's Disease (Psorospermosis follicularis vegetans).

the flexures of the joints, in the groins, and behind the ears.

Etiology.—The majority of cases of this incurable disease develop about puberty ; in a certain number hereditary predisposition can be established with certainty. Infectivity cannot be proven.

The **Histological characters** are very striking, and consist of changes in the epithelium, where special round glistening bodies are present in great numbers (the ‘corps ronds’ of Darier), as well as smaller granular masses. The disease is clearly defined as a distinct entity by the presence of these bodies, and must be strenuously differentiated from other somewhat similar affections—*e.g.*, certain forms of Ichthyosis —to which it has no relationship whatever.

The **Diagnosis** is extremely difficult on clinical characters only, and can only be rendered certain by a biopsy.

The **Prognosis** is unfavourable as regards recovery, but the general health is unaffected.

Treatment can, unfortunately, only be directed towards removing the seborrhoeic eczema which may be present ; vegetations may be destroyed by keeping the parts dry and touching with nitrate of silver or other caustics. The underlying, essential disease is rebellious to all treatment.

Fig. 173. Model in the Freiburg Dermatological Clinic (Johnsen).

Ichthyosis Simplex Serpentina.

SUPPLEMENT, PLATE IX., FIG. 174.

For Text, see Vol. I., page 54 *et seq.*

Fig. 174. Model in the Freiburg Dermatological Clinic (Johnsen).

The illustration shows most admirably the transition from almost imperceptible ichthyosis to the fully developed so-called ‘serpentine’ form, which is most marked in the vicinity of the elbows.





174. Ichthyosis simplex et serpentina.

Varicella.

Chicken-pox.

SUPPLEMENT, PLATE X., FIG. 175.

For Text, see Vol. I., pages 65 and 66.

Fig. 175. Model in Heubner's Clinic for Children in Berlin (Kolbow). The face is rather severely affected, scattered lesions being even present on the lips.

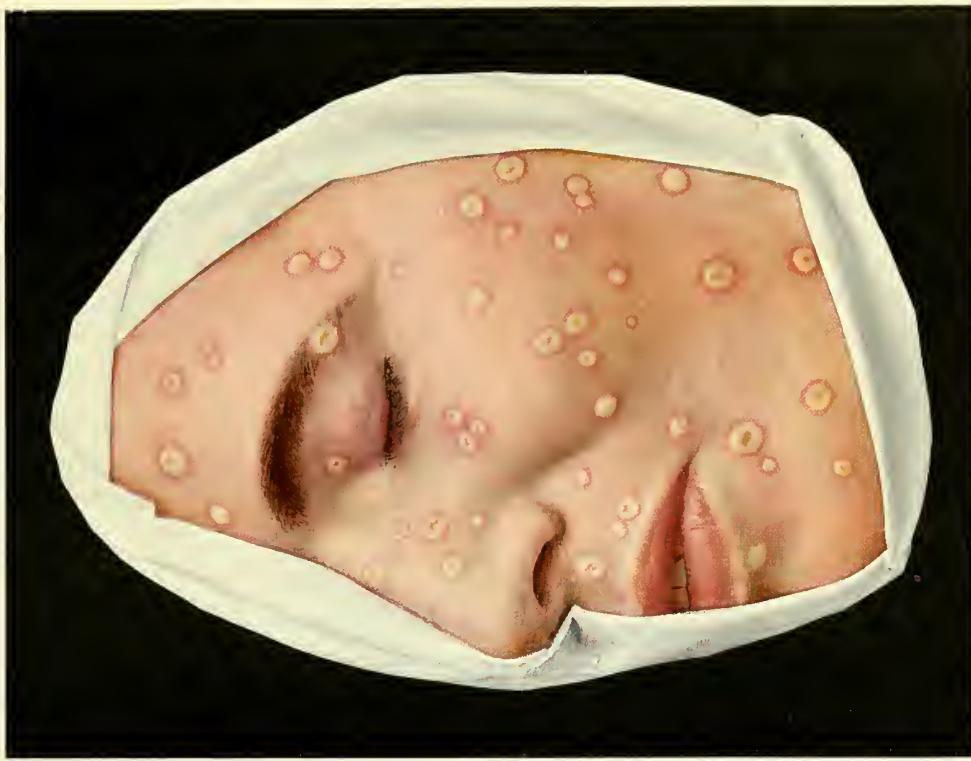
Variola Discreta.

Small-pox.

SUPPLEMENT, PLATE X., FIG. 176.

For Text, see Vol. I., page 58 *et seq.*

Fig. 176. Model by Kolbow in Berlin.



176. Variola discreta (Small-pox).



175. Varicella (Chicken-pox).



Vaccinia.

SUPPLEMENT, PLATE X., FIGS., 177, 178.

In vaccinated children the virus of the primary pustules may be transferred by scratching either to the surrounding skin or to distant parts—especially the genital regions and face—where secondary vaccine pustules may develop. If some itchy skin disease is present—*e.g.*, eczema, scabies, or prurigo—the condition may result in an outbreak of vaccinal lesions over the whole body (Fig. 178), with severe general symptoms. This usually occurs like a relapse two or three weeks after the vaccination, and is often considered as a general infection with vaccine matter. The disease almost always runs a favourable course, but leaves behind it annoying scars, and may, if the cornea is attacked, give rise to damaging opacities or even to total loss of vision. It is also possible for vaccine virus to be transferred from recently vaccinated persons to children who have not been vaccinated, but who are the subjects of itching skin diseases.

The **Diagnosis** can be easily established by the presence of the typical lesions and the determination of a preceding vaccination, possibly of a relative or neighbour.

The **Prognosis** is favourable as a rule.

Prophylaxis is of great importance. Children suffering from itchy skin diseases ought not to be vaccinated until the skin disease is quite cured. All vaccination pustules must be covered with a protective antiseptic dressing.

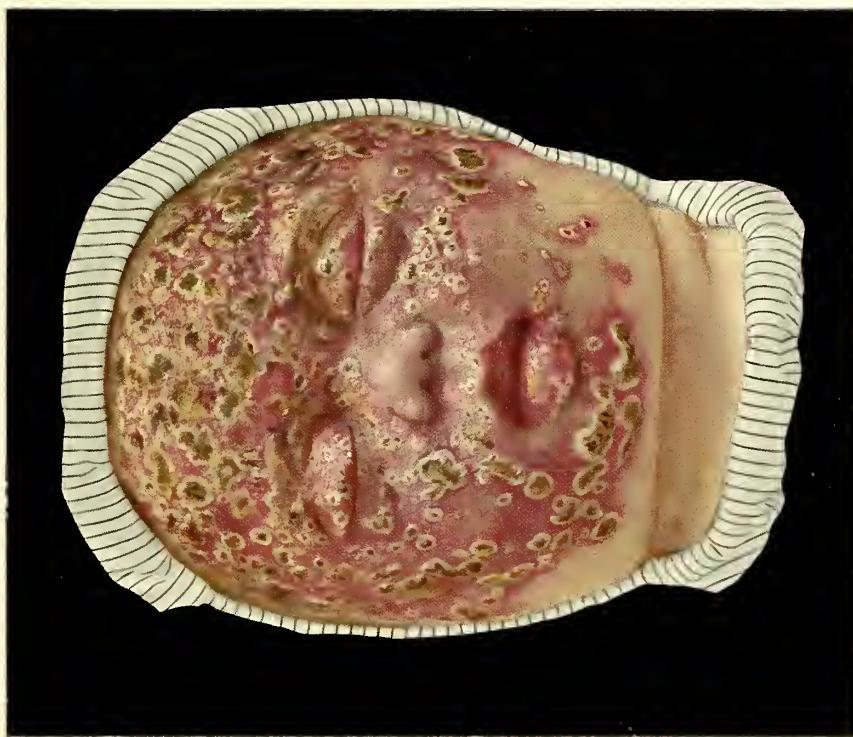
Treatment.—In every recent case of vaccinia an attempt should be made to employ Finsen's method of excluding all chemically active light rays. If the pustules are fully developed, wet compresses may be employed soaked in acetate of aluminium, or boric acid, or 1 per cent. resorcin solution. Painting with pure ichthyol or the use of ichthyol ointment may also be recommended.

Fig. 177. Model in the Imperial Vaccine Institute in Vienna
(Dr. Henning).

Fig. 178. Model in Finger's Clinic in Vienna (Dr. Henning).



177. 178. *Vaccinia generalisata.*





Pemphigus Foliaceus.

SUPPLEMENT, PLATE XII., FIG. 179.

For Text, see Vol. I., page 80 *et seq.*

Fig. 179. Model in Neisser's Clinic in Breslau (Kröner).

Folliculitis Barbæ.

Sycosis.

SUPPLEMENT, PLATE XIII., FIG. 180.

For Text, see Vol. II., pages 89 and 90.

Fig. 180. Model in Neisser's Clinic in Breslau (Kröner).



179. *Pemphigus foliaceus.*

Dermatitis Papillaris Capillitii.

Acne-Cheloid.

SUPPLEMENT, PLATE XIII., FIG. 181.

This disease has also been called ‘Acne-Cheloid,’ although it has no relationship whatever with acne. The lesions are present on the neck at the margin of the hairy scalp, and consist of small, firm nodules covered with scab. Then these rise up close together and coalesce; very hard, pale red, raised plaques result, from which a few hairs emerge arranged in bundles, and these hairs are difficult to extract. Destruction of large areas is of rare occurrence. The disease is a distinct one; it gives rise to no pain, and is extremely tedious in its course; spontaneous recovery sometimes takes place after years. Its cause is unknown; the comparatively frequent occurrence of this rare disease in soldiers is striking, being possibly the result of the tight neck-band they wear.

The **Diagnosis** can be made without difficulty from the localization of the disease, the hardness of the nodules, and the presence of the characteristic bundles of hair.

The **Prognosis** as regards complete cure is very dubious.

The results hitherto obtained by **Treatment** are far from encouraging. The most efficacious remedy is a well-made mercurial plaster ; but scarification, needling, epilation, electrolysis, and 'light treatment' may be tried.

Fig. 181. Model in the Freiburg Dermatological Clinic (Johnsen).



181. Dermatitis papillaris capillitii (Acne-cheloid).



180. Folliculitis barbae (Sycosis).



Acne ex Usu Iodi.

Iodide Rash.

SUPPLEMENT, PLATE XIV., FIG. 182.

For Text, see Medicinal Rashes, Vol. II., page 94
et seq.

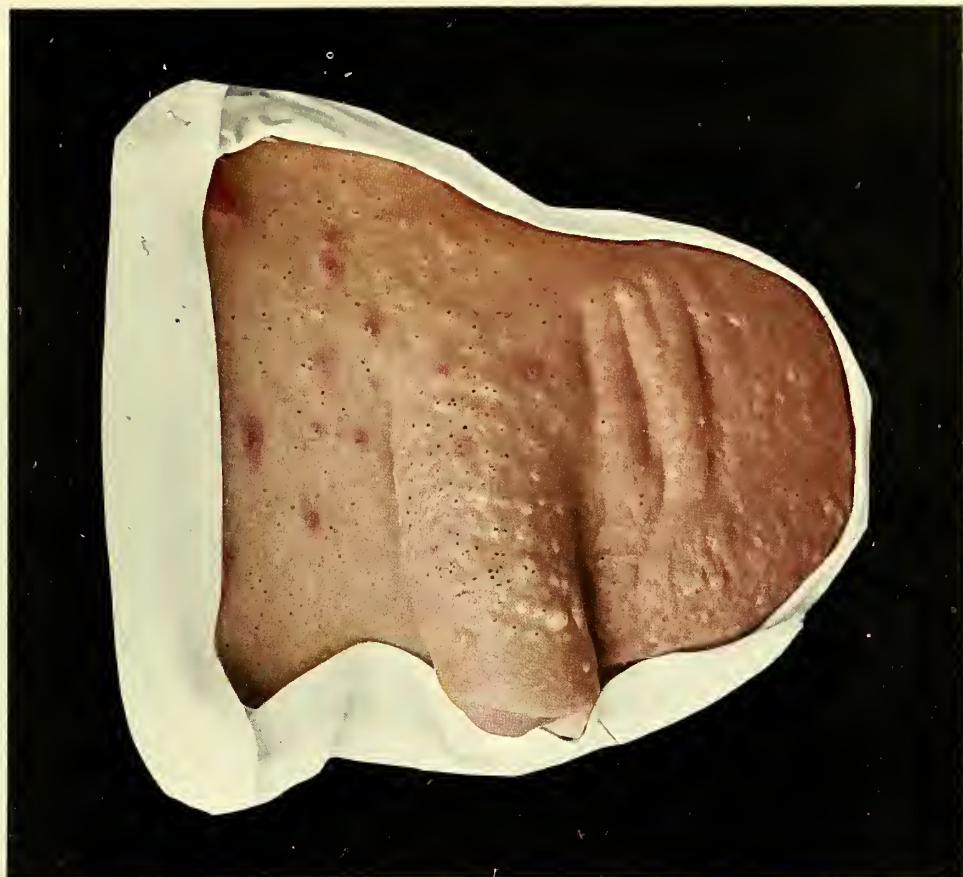
Fig. 182. Model in the Freiburg Dermatological Clinic (Johnsen).

Acne e Fabricatione Chlori.

Chlorine Acne.

SUPPLEMENT, PLATE XIV., FIG. 183.

Persons employed in the production of chlorine and caustic soda by electrolysis of common salt are liable, after long periods of employment in certain departments of the works, to a progressive disease of the skin of the face, genitals and trunk, accompanied by severe damage to the general health. The other parts of the body are affected to only a very slight degree. At first numerous, closely agglomerated, tiny comedones form, especially around the eyes, in the temporal regions and behind the ears, as the result of which the face assumes a peculiar ashy-gray discoloration, a similar condition being also present in the genital regions. The comedones increase in number and size, finally completely blocking the follicles, so that they develop into small milia or cysts, on the apices of which the heads of the comedones show themselves as black points (Fig. 183). The chest and back exhibit a similar state of affairs, but only small comedones in varying number develop on the arms. In a certain proportion of cases—especially after prolonged exposure to the exciting cause—the comedones and cysts, particularly on the chest and back, are converted into painful



183. Acne e fabricatione Chlori (Chlorine Rash).



182. Acne ex usu Iodi (Iodide Rash).

nodules as the result of secondary infection, and these may coalesce to form extensive infiltrates. Even if the patient abandon his work, the disease may be greatly prolonged by successive exacerbations, but it finally recovers. Some of the patients die of tuberculosis. It is noteworthy that both women and children, even those who have never followed the occupation in question, may suffer from the disease, although generally to a very slight extent. Exactly the same disease has been observed in some workers in hydrochloric acid manufactories, and it is highly probable that the active agents in the causation of the disease are some tar-chlorine derivatives which, ingested by the mouth, provoke the eruption while excreted from the follicles.

The **Diagnosis** is easily determined by the localization of the lesions and a consideration of the occupation of the patients.

The **Prognosis** is favourable in slight, but must be guarded in severe, cases.

The results of **Treatment** are not very encouraging. Most important is **Prophylaxis**; all workers in such works as have been referred to must be carefully observed, and must be immediately transferred to some other department on the first appearance of any comedones. There seems some possibility that the risks of occurrence of Chlorine Acne may be entirely obviated by modifications in the methods of manufacture employed, in the sense of complete dissociation of the tar.

Fig. 183. Model in the Freiburg Dermatological Clinic (Johnsen).

Toxicodermia Mercurialis.

Mercurial Rash.

SUPPLEMENT, PLATE XV., FIG. 184.

For Text, see Vol. II., page 95.

Eruptions from mercury are most frequently observed after the external application of that drug, especially after inunctions employed either for the cure of syphilis or for the destruction of pediculi pubis. They generally appear as flat, livid or bright red papules, closely aggregated and generally universal in distribution. In predisposed persons, however, such eruptions may result—although not frequently—from the internal or subcutaneous use of mercury.

Fig. 184. Model in Neisser's Clinic in Breslau (Kröner).

Rhinoscleroma.

SUPPLEMENT, PLATE XV., FIG. 185.

This scleromatous condition of the nose and its mucous lining is caused by a specific encapsulated bacillus. It generally begins in the nostrils by the formation of a growth embedded in the nasal tissue, which is of ivory-like hardness, sensitive to touch, and covered by tense skin or mucous membrane. The condition may extend into the larynx, and thus give rise to respiratory disturbances. As a result, the nose appears thickened, often of a bluish-red colour, and sometimes portions of the hypertrophied and sclerosed mucous membrane protrude from the nostrils (Fig. 185). In process of time the disease may invade the greater part of the skin of the face, as well as the buccal and nasal mucous membrane, but neither general symptoms nor extensive ulcerative destruction of the new growth ensue.

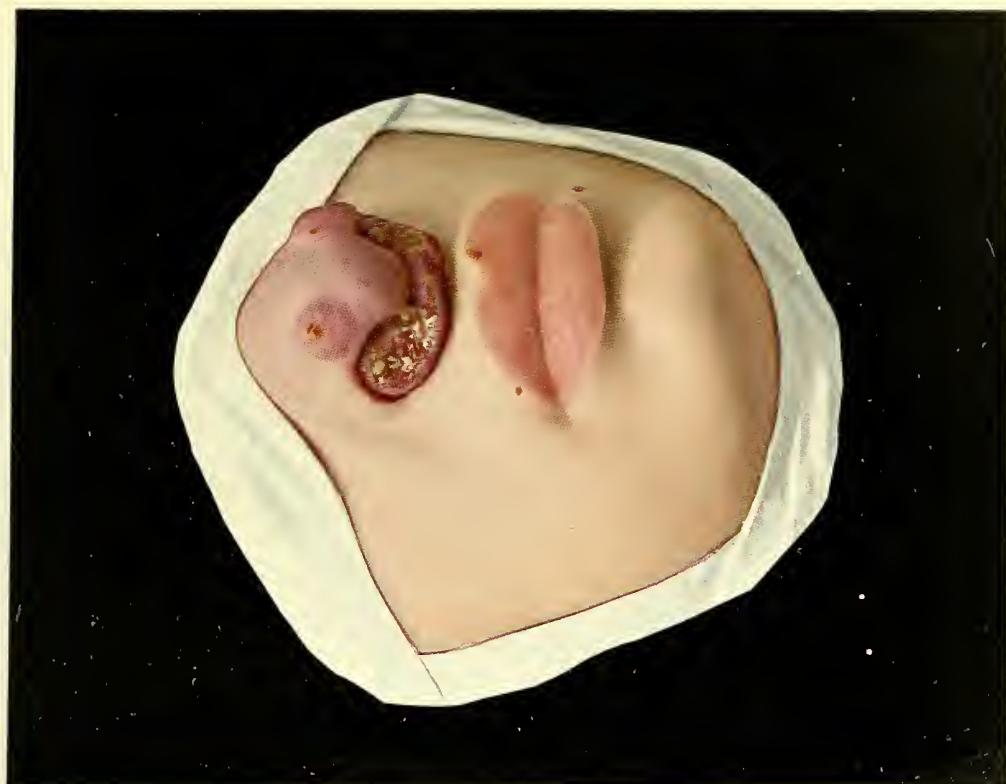
In some parts of the world rhinoscleroma is observed as an endemic condition ; isolated cases are rare.

The **Diagnosis** is based upon the localization of the growth, and its slow extension.

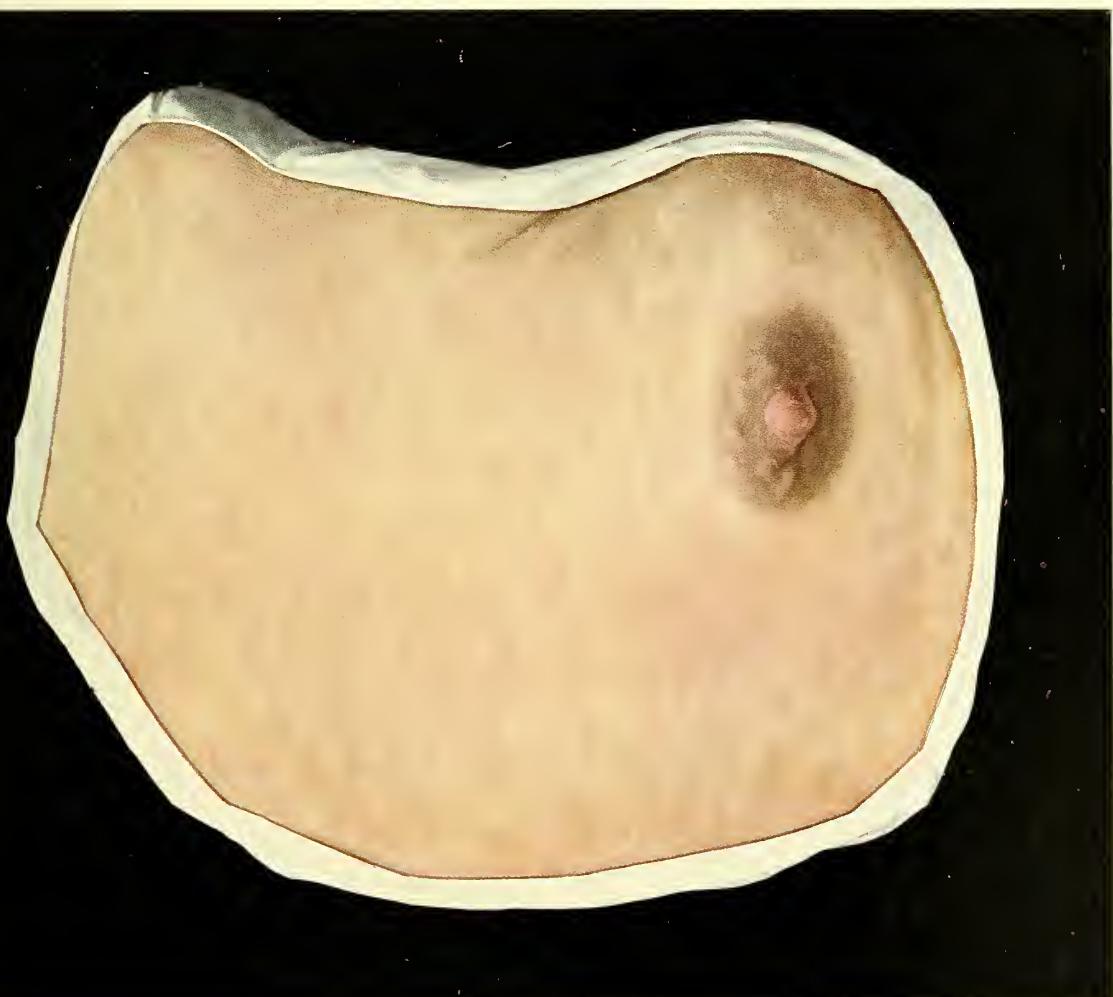
The **Prognosis** is unfavourable as regards life only when the larynx is involved, and there is risk of asphyxia ; but complete cure is never attained.

No satisfactory mode of **Treatment** is yet known. Surgical measures are productive of only temporary improvement, at the best. Caustics may be tried, such as pyrogallic acid, or chromic acid and nitrate of silver for mucous membranes. X rays are also worthy of consideration.

Fig 185. Model in Saint Louis Hospital in Paris, No. 1615
(Baretta). Besnier's Case.



185. Rhinoscleroma.



184. Toxicodermia mercurialis (Mercurial Rash).

Scleroderma Diffusa.

SUPPLEMENT, PLATE XVI., FIG. 186.

For Text, see Vol. II., page 97 *et seq.*

Fig. 186. Model in Freiburg Dermatological Clinic (Johnsen).
The universal form of scleroderma in a woman aged forty-two years, who was suddenly attacked with swellings about the ankles seven months previously. Ever since the skin of the whole body had been of board-like hardness, shiny and deeply pigmented, with scattered, lighter spots and excoriations here and there, especially about the ankylosed joints. The patient became intensely emaciated, and died of an acute pleurisy with effusion.

Atrophia Cutis Idiopathica.

SUPPLEMENT, PLATE XVI., FIG. 187.

Idiopathic atrophy of the skin has only been recorded in recent years, although in a comparatively frequent number of cases. Its etiology is unknown. It is usually localized on the extremities, where either scattered spots or larger surfaces of skin and subcutaneous tissue shrink, while hairs and cutaneous glands atrophy, until the skin—which is greatly thinned and in folds, like crumpled cigarette-paper—appears too big for the limbs which it covers. The colour of the diseased parts is whitish or reddish—the latter tint being especially marked on the recently affected parts, which exhibit patchy lividity—and is also pigmented, with a peculiar variegated appearance. The dilated and tortuous bloodvessels are visible through the transparent skin (Fig. 187). Inflammatory phenomena are present in the earliest initial stages, but the process, after attaining its maximum with more or less rapidity, remains stationary, and produces no important disturbance of sensation or of the general health.

The **Diagnosis** is easily made from the characteristic symptoms of the disease. It may be observed that atrophy of the skin, especially of the lower extremities, also occurs as a congenital condition.



186. Scleroderma diffusa.



187. Atrophie cutis idiopathica.

The **Prognosis** is favourable as far as general health is concerned, but absolutely unfavourable as regards recovery. Hitherto no improvement has been noted in parts once affected.

Treatment is unavailing ; in the earlier stages warm baths and massage might perhaps be tried.

Fig. 187. Model in Neisser's Clinic in Breslau (Kröner).

Carcinoma Epitheliae Cicatrisans.

Rodent Ulcer.

SUPPLEMENT, PLATE XVII., FIG. 188.

For Text, see Vol. II., page 121 (Rodent Ulcer).

New carcinomatous changes may occur in the apparently healed parts of those comparatively benign forms of epithelioma of the skin (rodent ulcer) which tend to cicatrize in the centre and spread at the periphery (Fig. 188). In such the prognosis is less favourable than in the majority of cases.

Fig. 188. Model in Neisser's Clinic in Breslau (Kröner).



188. Carcinoma epitheliale cicatrisans.

Carcinoma Linguae. Carcinoma Penis.

SUPPLEMENT, PLATE XVIII., FIGS. 189, 190.

In addition to the comparatively benign rodent ulcer, there also occur in middle and advanced life more malignant forms of primary carcinoma which occasionally attack intact epidermis, but more frequently develop upon chronic ulcerative processes such as lupus and late syphilis, or upon keratoses, senile warts, etc. The mucous membrane of the lips and tongue not infrequently is the starting-point of carcinomatous new growths. These generally begin as hard nodules, which break down to form ulcers or undergo transformation into malignant papillomata (Figs. 189, 190). The latter form is especially common on the penis. Extremely marked malignancy often manifests itself by uncontrollable extension of the disease, both in area and in depth, by pain, haemorrhage, implication of the corresponding glands, and by progressive cachexia.

The **Diagnosis** may be grounded on the hardness—especially of the margin—of the nodular growths, on the glandular swellings, and on taking into consideration the age of the patient. If we are dealing with a carcinoma *ab initio*, the differential diagnosis from syphilis and tuberculosis (especially lupus) must be especially established; the former malady may be

eliminated from the diagnosis by the failure of anti-syphilitic treatment, the latter by the absence of reaction to injections of the original tuberculin. In doubtful cases a biopsy is always the best procedure.

The **Prognosis** is least unfavourable in cases diagnosed very early, but in general it is very unsatisfactory.

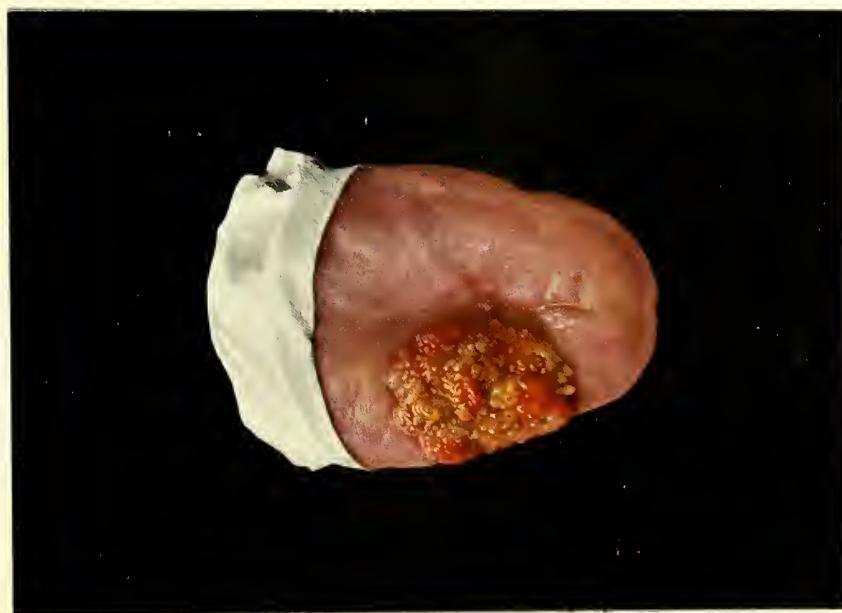
The best **Treatment** is the surgical removal of the parts, cutting wide into the healthy tissues, and at the same time taking away all diseased or suspicious glands. If the situation of the growth does not permit of this radical procedure, or if recurrences take place in the scars, treatment with X rays yields many good results. Caustics, the sharp spoon, and Paquelin cauterization may certainly cause temporary cicatrization, but almost never accomplish a permanent cure.

Fig. 189. Model in Saint Louis Hospital in Paris, No. 1557
(Bareta). Hallopeau's case.

Fig. 190. Model in Neisser's Clinic in Breslau (Kröner).



190. Carcinoma penis.



189. Carcinoma linguae.



Sarcoma e Nævo Pigmentoso.

SUPPLEMENT, PLATE XIX., FIG. 191.

For Text, see Vol. II., page 123.

Fig. 191. Model in Bergmann's Clinic in Berlin (Kolbow).

Adenoma Sebaceum.

SUPPLEMENT, PLATE XIX., FIG. 192.

This disease of the face, to which the above name was first applied by Balzer and Ménétrier, who also first accurately described it, is characterized by the appearance about puberty of numerous yellowish or reddish nodular growths of various sizes, which are especially closely aggregated in the naso-labial folds. Its subjects are almost always epileptics or idiots. No further changes occur in the growths.

The **Diagnosis** is easily made from the characteristic but typical features of the disease.

The **Treatment** recommended consists in the destruction of the separate nodules by galvano-cautery, excision, or electrolysis.

Fig. 192. Model in Neisser's Clinic in Breslau (Kröner).



192. Adenoma sebaceum.



191. Sarcoma e naevo pigmentoso.



Mycosis Fungoides in the Eczematoid Stage.

SUPPLEMENT, PLATE XX., FIG. 193.

For Text, see Vol. II., page 125.

Fig. 193. Model in Neisser's Clinic in Breslau (Kröner).

Xanthoma Tuberousum Multiplex.

SUPPLEMENT, PLATE XXI., FIG. 194.

For Text, see Vol. II., page 117.

Fig. 194. Model in Saint Louis Hospital in Paris, No. 655
(Baretta). Besnier's case.



193. Mycosis fungoides; in the eczematoid stage.



Xanthoma Planum Volæ Manus.

Xanthoma of the Palm.

SUPPLEMENT, PLATE XXI., FIG. 195.

For Text, see Vol. II., page 117.

Fig. 195. Model in Saint Louis Hospital in Paris (Baretta).
Du Castel's case.

Eczema Chronicum Volæ Manus.

Chronic Eczema of the Palm.

SUPPLEMENT, PLATE XXII., FIG. 196.

For Text, see Vol. II., page 126 *et seq.*

Fig. 196. Model in Freiburg Dermatological Clinic (Johnsen).



I95. Xanthoma planum volae manus.



I94. Xanthoma tuberosum multiplex.



197. Eczema corneum plantae pedis.



196. Eczema chronicum volae manus corneum.



Eczema Corneum Plantæ Pedis.

Chronic Eczema of the Sole.

SUPPLEMENT, PLATE XXII., FIG. 197.

For Text, see Vol. II., page 126 *et seq.*

Fig. 197. Model in Saint Louis Hospital in Paris, No. 770
(Baretta). Fournier's case.

Eczema Crustosum Mammæ.

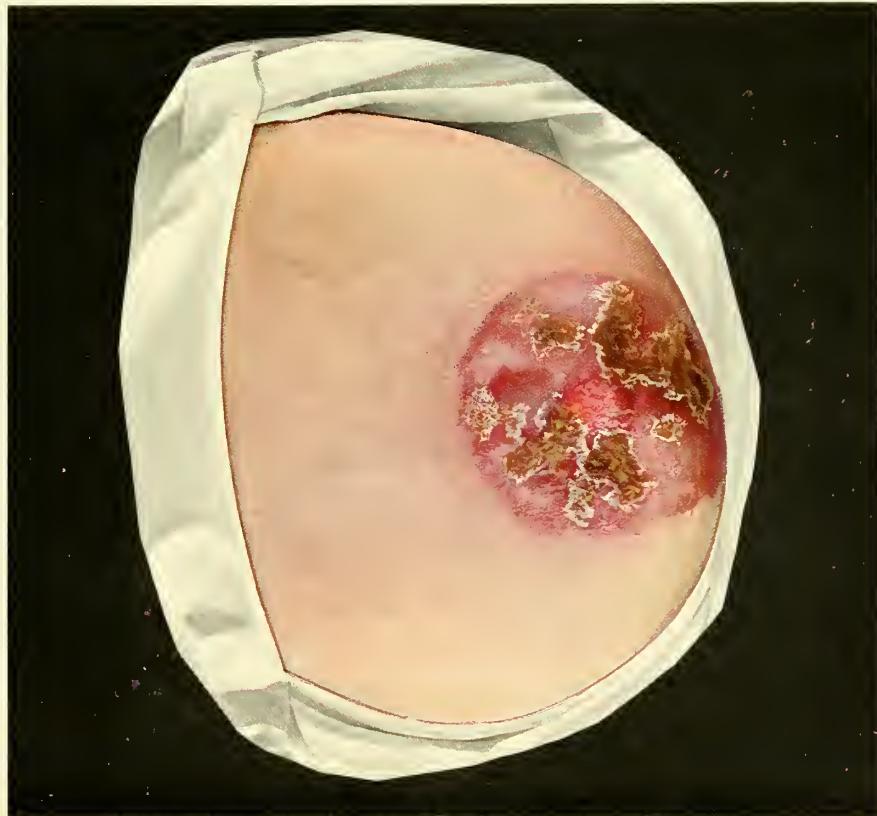
Eczema of the Nipple.

SUPPLEMENT, PLATE XXIII., FIG. 198.

For Text, see Vol. II., page 126 *et seq.*

Crusted eczema of the nipple and the surrounding parts occurs principally in women with children at the breast, as the result of the decomposition of milk remaining on the mammilla, and of the mechanical irritation of suckling. The fissures which result from it are very painful, so that further nursing becomes impossible.

Fig. 198. Model in Max Joseph's Polyclinic in Berlin (Kolbow).



198. Eczema crustosum mammae.



199. Eczema madidans axillae.



Eczema Madidans Axillæ.

Weeping Eczema of the Armpit.

SUPPLEMENT, PLATE XXIII., FIG. 199.

For Text, see Vol. II., page 126 *et seq.*

Fig. 199. Model in Freiburg Dermatological Clinic (Johnsen). Weeping and scabbing eczema of the armpits in a very fat, sweaty man in whom the genitals and surrounding parts, the anal and the umbilical regions were also eczematous.

Eczema e Pediculis Capitis.

Pediculosis of Scalp with Secondary Eczema.

SUPPLEMENT, PLATE XXIV., FIG. 200.

For Text, see Vol. II., page 126 *et seq.*

Fig. 200. Model in Freiburg Dermatological Clinic (Johnsen).



201. Pediculosis vestimentorum.



200. Eczema e pediculosis capitis.



Pediculosis Vestimentorum.

Body Lice.

SUPPLEMENT, PLATE XXIV., FIG. 201.

For Text, see Vol. II., page 144.

Fig. 201. Model in Neisser's Clinic in Breslau (Kröner).

Myiasis Linearis.

Creeping Eruption.

SUPPLEMENT, PLATE XXV., FIG. 202.

The very peculiar morbid condition described under the names of Creeping Eruption, Larva migrans, or 'Hautmaulwurf,' is the result of the migrations in the epidermis of a parasite, probably of a *Gastrophylus*, or larva of one of the *Œstridae* (gadflies). The animal digs long, straight, zigzag, or curved and often intersecting, but never bifurcating, lines ; these cause great itching over the part in which the parasite is situated, where there is an inflammatory red area. Moreover, the burrows may extend as much as from 1 to 15 centimetres in twenty-four hours, and show themselves as delicate, red lines which gradually fade away (Fig. 202). The disease is common in some parts of Russia, but also occurs in Germany and elsewhere.

The **Diagnosis** is easily established.

Treatment consists in digging out the animal or in excising the portion of skin in which it is located ; it is, however, necessary to excise a considerable piece in order to be sure that the larva is removed.

Fig. 202. Model in Finger's Clinic in Vienna (Dr. Henning).



203. Onychogryphosis.



202. Myiasis linearis (Creeping Eruption).



Onychogryphosis.

SUPPLEMENT, PLATE XXV., FIG. 203.

An alteration in shape of the nails, which may attain very various degrees of severity, sometimes occurs in old people either as the result of chronic pressure from boots or, less frequently, of chronic inflammation of the nail matrix. The condition generally affects the nails of the big toes, but sometimes those of the other toes as well. In slight cases the nail is simply raised from its bed by a white horny mass, but in severe cases the nail is greatly thickened, becomes very dark in colour, is furrowed both transversely and longitudinally, grows perpendicularly upwards or sideways, and assumes a claw-like or spiral form.

The **Diagnosis** presents no difficulties.

Treatment must first be directed towards an attempt to remove the horny mass by some process of maceration such as prolonged bathing, painting, with caustic potash, or the application of salicylic plaster muslins or soap-plasters with a view to softening it, after which it can be mechanically removed. Afterwards tar or salicylic plaster dressings are employed to prevent the re-formation of horny matter or to keep it within certain limits. Surgical removal of the entire nail matrix is only to be recommended in extreme cases, as the absence of nails, especially on the big toes, is found to be extremely unpleasant.

Fig. 203. Model in Freiburg Dermatological Clinic (Johnsen).

Elephantiasis Penis et Scroti.

SUPPLEMENT, PLATE XXVI., FIG. 204.

Blocking of the corresponding lymphatics ensues as the result of relapsing inflammatory processes (eczema, erysipelas) or of lupus, gummatous syphilis, ulcers of the leg, etc., and this may cause persistent œdema, which, in process of time, brings about marked increase in bulk of the skin and subcutaneous tissue of the affected parts. In extreme cases the muscles and bones participate in the hypertrophy. The skin may be smooth, shiny, and tense, or may exhibit ulcers, papillary growths and callosities, or, ultimately, dilatations of blood or lymphatic vessels. Elephantiasis is most frequent on the extremities, the legs being its commonest seat; it also often attacks the genitals—where it may assume most repulsive forms—and the face. Sometimes none of the aforementioned causes can be determined, and even tangible changes in the blood and lymphatic systems may be absent. In marked Elephantiasis the annoyance caused by the swellings may be extreme.

The tropical form of Elephantiasis, which is due to the migration of the *Filaria sanguinis* into the lymphatic vessels of the skin, must be differentiated from the morbid condition above described.



204. Elephantiasis penis et scroti.



The **Diagnosis** of Elephantiasis presents no difficulty ; the determination of the cause of the disease is more difficult, as the morbid process which has given rise originally to the changes present may have disappeared without leaving traces of its nature.

The **Prognosis** is favourable as far as life is concerned, but less pleasing as regards the prospect of recovery.

Prophylaxis is of the greatest importance ; its object must be to prevent the occurrence and combat the effects of those forms of inflammation which, as experience teaches, may result in Elephantiasis—*e.g.*, recurrent erysipelas and eczema.

Treatment.—In the early stages energetic mechanical treatment may sometimes prove remedial or even curative, especially baths, massage, strapping and Bier's passive-congestion method. In more severe cases it is not unfrequently necessary to obviate functional disturbances by excision or amputation.

Fig. 204. Model in the Cochin Hospital in Paris (Jumelin). Mauriac's case.

Syphilis.

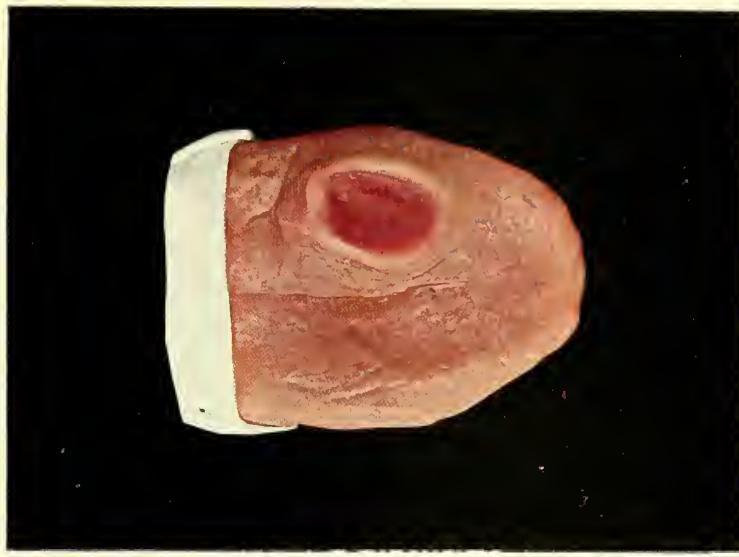
SUPPLEMENT, PLATE XXVII. TO PLATE XXXIX.

FIGS. 205 TO 231.

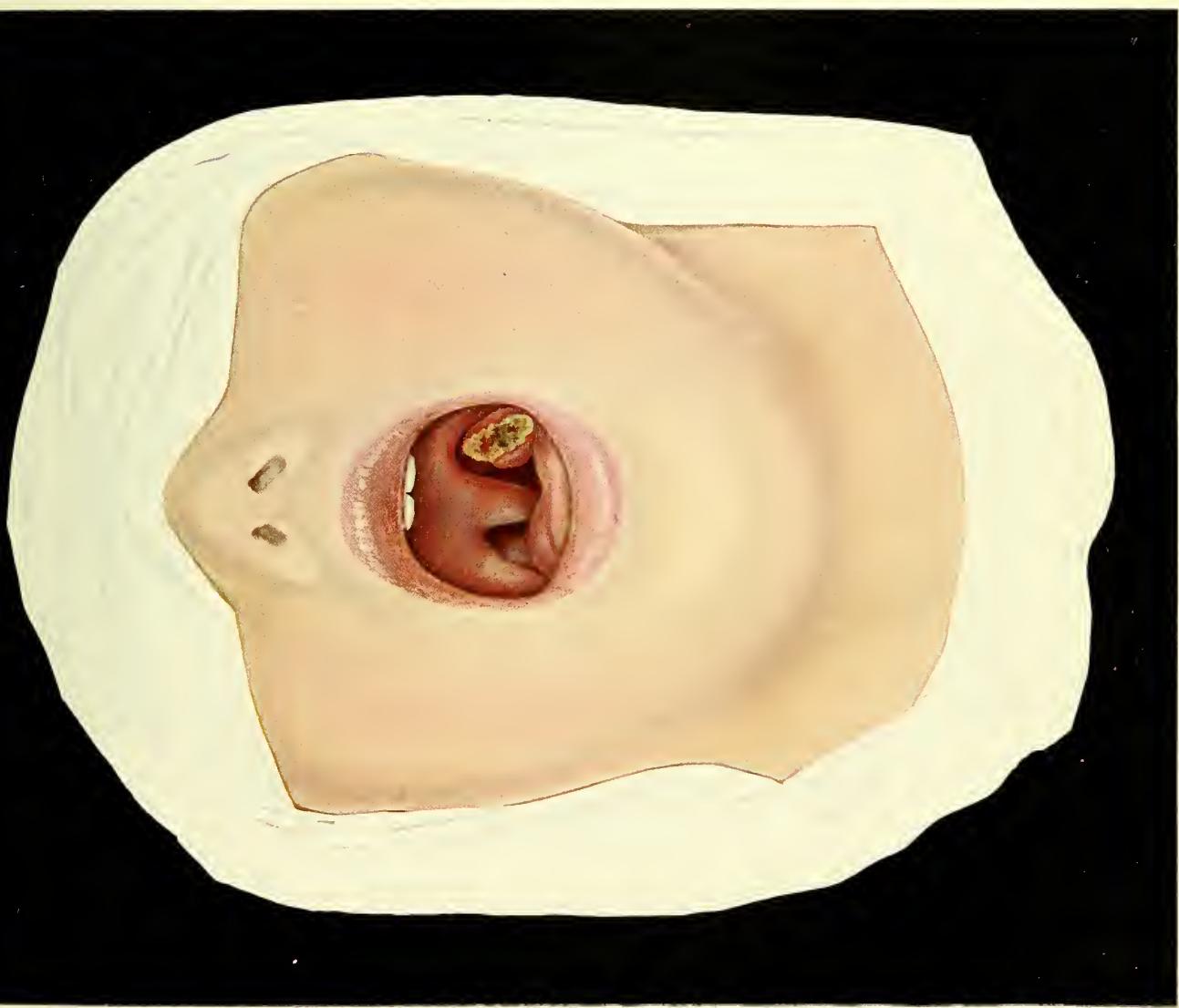
For Text, see Vol. II., pages 149-166.

- Fig. 205. Model in Saint Louis Hospital in Paris, No. 306 (Jumelin). Fournier's Collection.
- Fig. 206. Model in Bergmann's Clinic in Berlin (Kolbow).
- Fig. 207. Model in Leopold's Clinic for Women in Dresden (Kolbow).
- Fig. 208. Model in Buschke's Department in Urban's Hospital in Berlin (Kolbow).
- Fig. 209. Model in the Cochin Hospital in Paris (Jumelin). Mauriac's case.
- Fig. 210. Model in Freiburg Dermatological Clinic (Johnsen).
- Fig. 211. Model in Freiburg Dermatological Clinic (Johnsen).
- Fig. 212. Model in Saint Louis Hospital in Paris, No. 1786 (Baretta). Hallopeau's case.
- Fig. 213. Model in Freiburg Dermatological Clinic (Johnsen).
- Fig. 214. Model in Werther's Department in Friedrichstadt Hospital in Dresden (Kolbow).
- Fig. 215. Model in Freiburg Dermatological Clinic (Johnsen).
- Fig. 216. Model in Max Joseph's Polyclinic in Berlin (Kolbow).
- Fig. 217. Model in Werther's Department in Friedrichstadt Hospital in Dresden (Kolbow).
- Fig. 218. Model in Saint Louis Hospital in Paris, No. 417 (Jumelin). Fournier's Collection.
- Fig. 219. Model in Jullien's Department in Saint Lazare Hospital in Paris (Jumelin).
- Fig. 220. Model in Saint Louis Hospital in Paris, No. 678 (Baretta). Lailler's case.

206. Sclerosis syphilitica linguae.



205. Sclerosis syphilitica tonsillae.





207. Sclerosis labii majoris.



208. Sclerosis et oedema indurativum in infante.



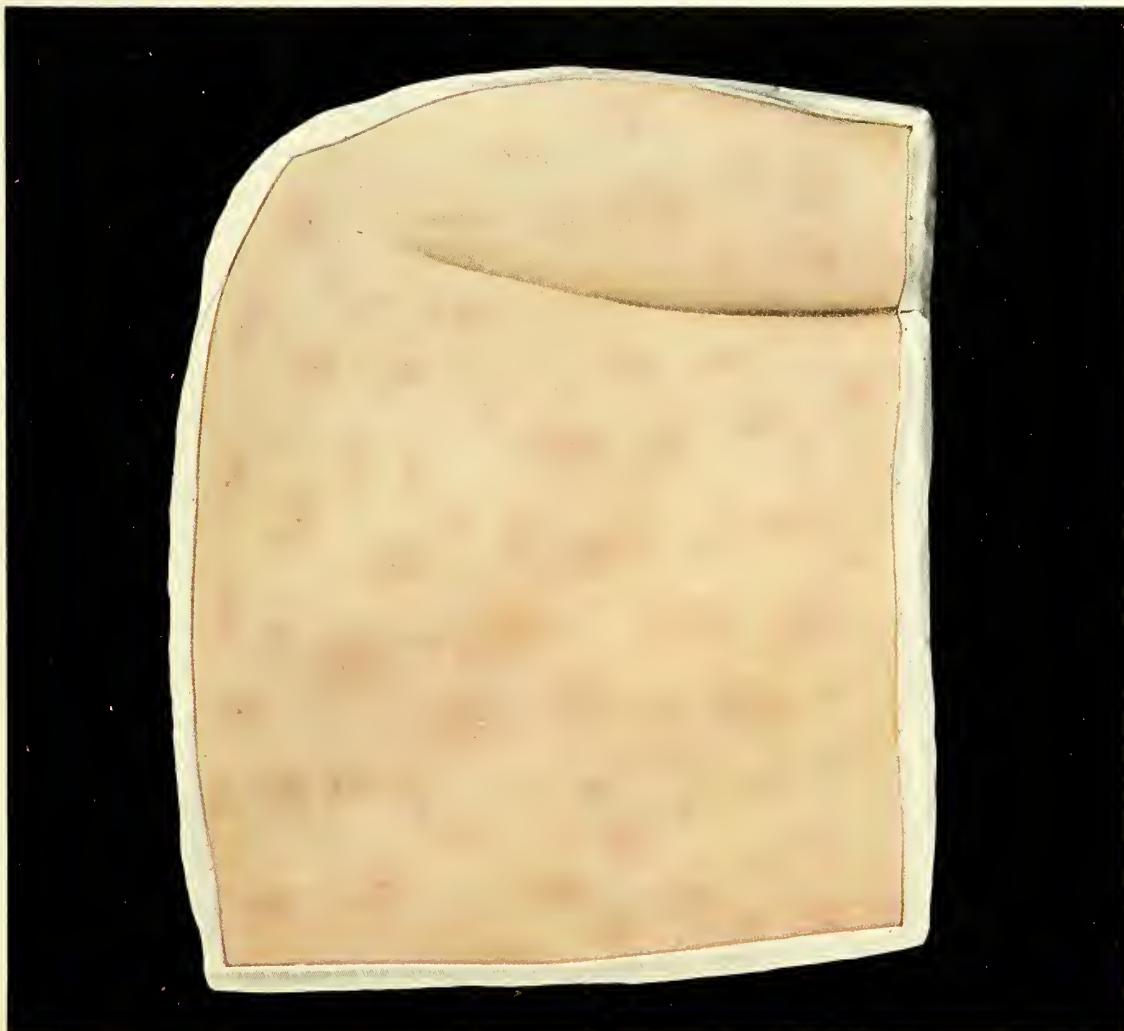
209. Sclerosis phagedenaica.



210. Syphilis maculosa confluens; Leucodermia syphilitica.



212. Syphilis papulosa annularis.



211. Syphilis maculosa follicularis.



214. Syphilis papulo-pustulosa.



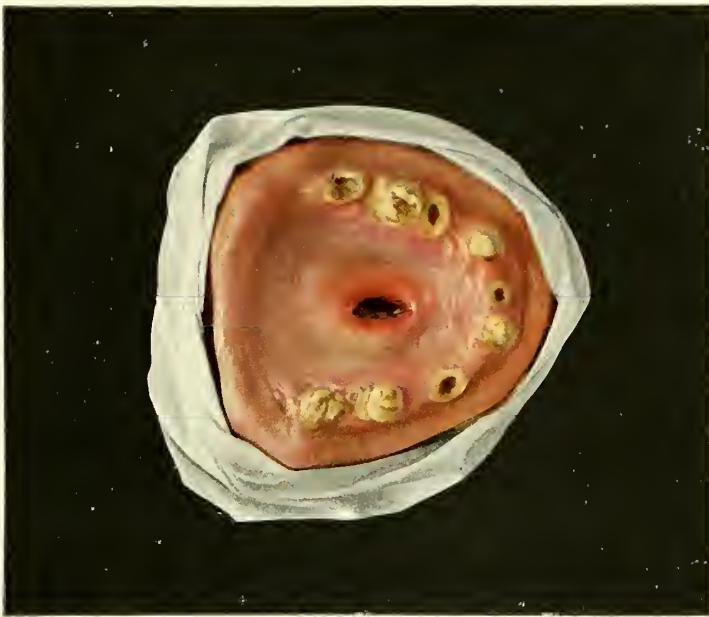
213. Syphilis papulo-squamosa.



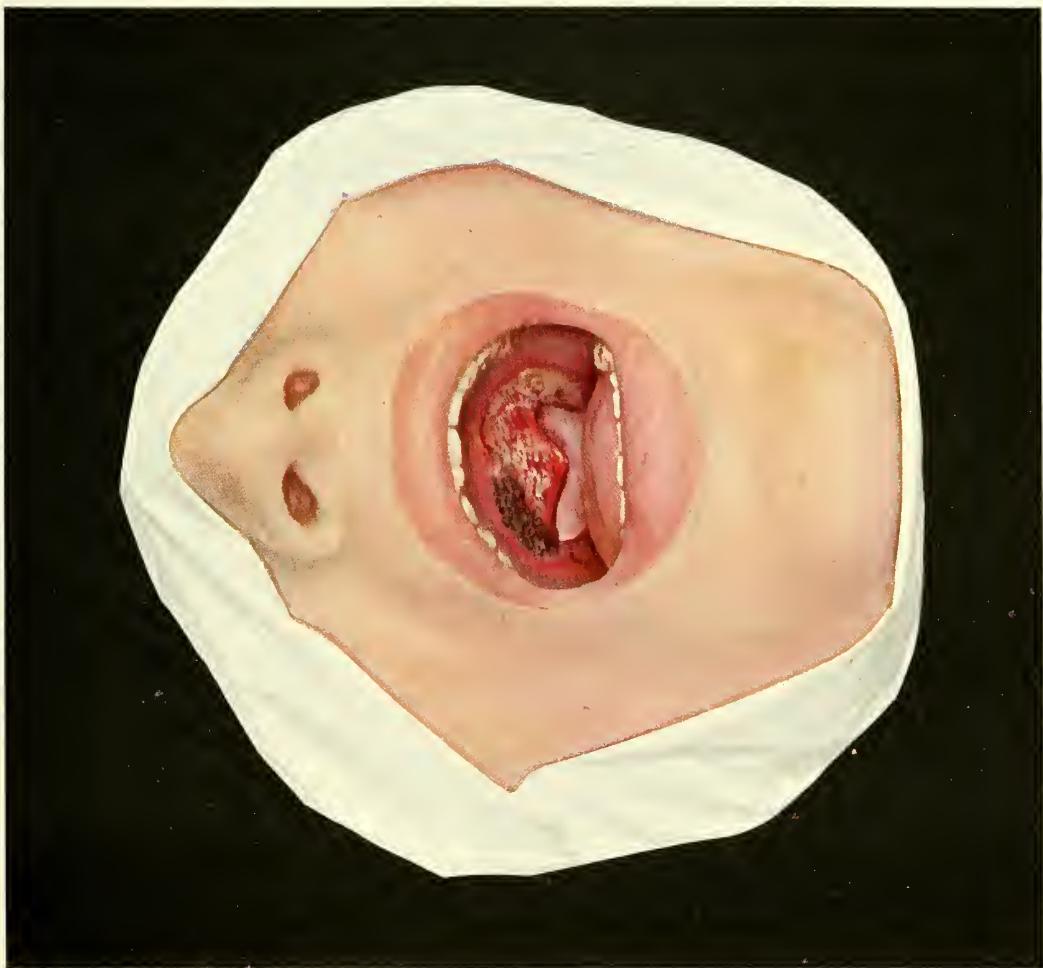
216. Syphilis papulosa (Flat Condylomata).



215. Syphilis papulosa linguae.



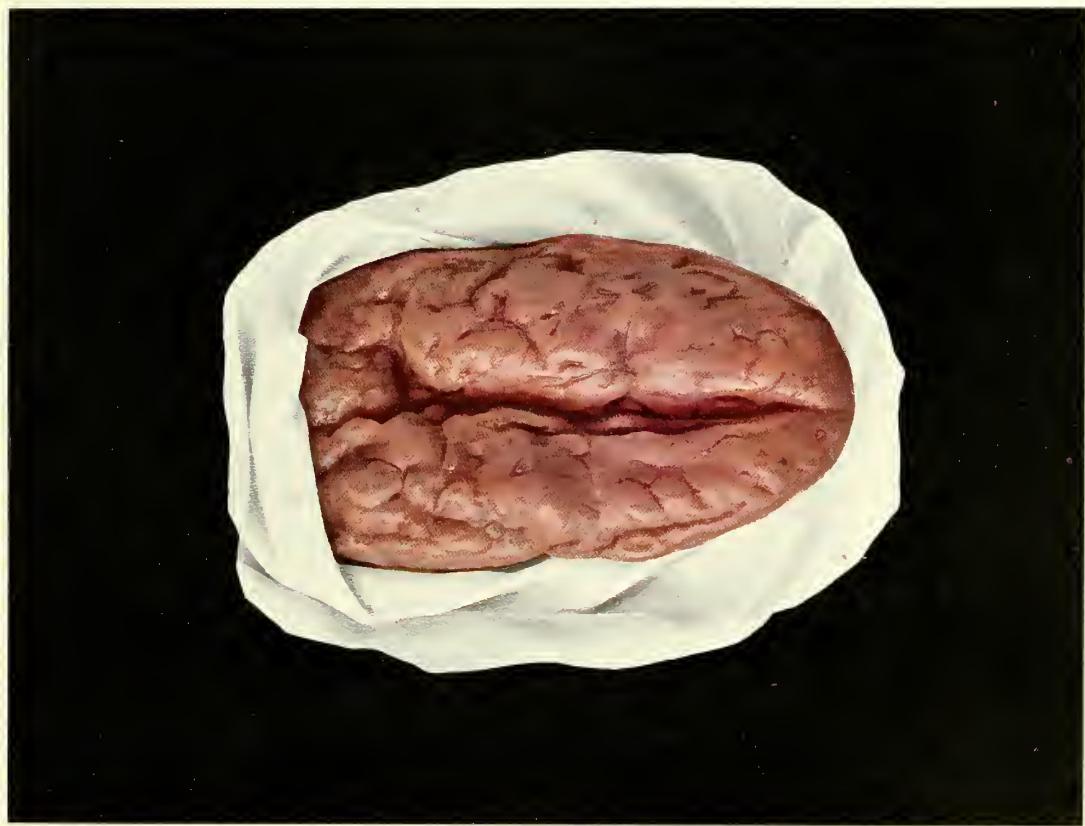
218. Syphilis ulcerosa palati duri.



217. Syphilis ulcerosa palati mollis.



220. *Syphilis gummosa digitii.*



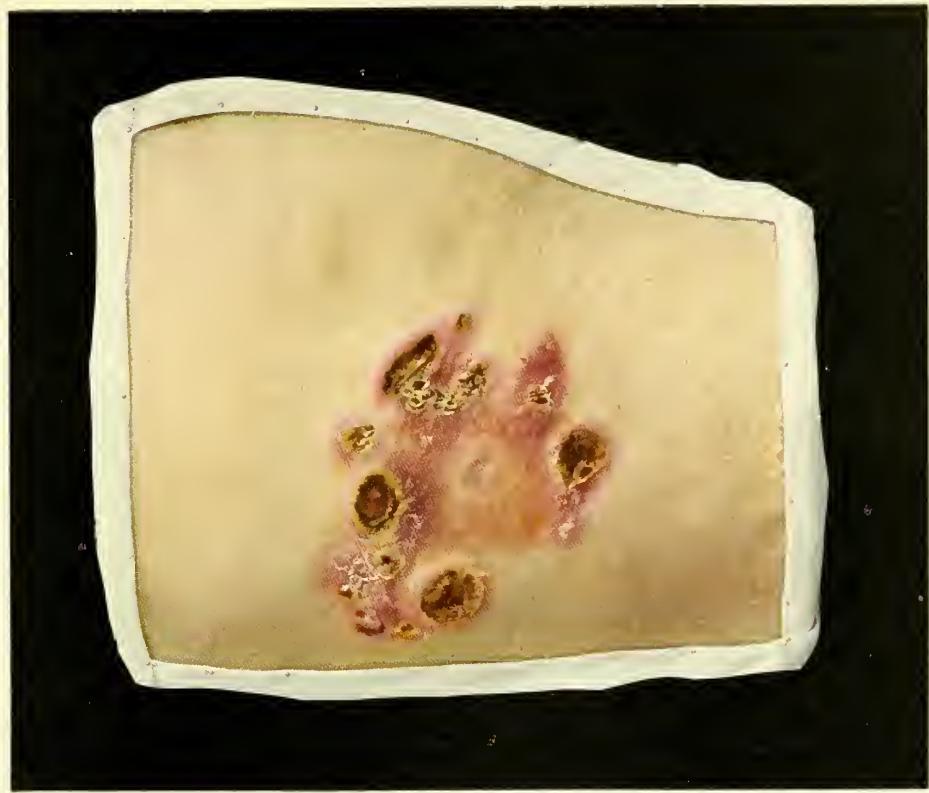
219. *Syphilis gummosa linguae diffusa.*



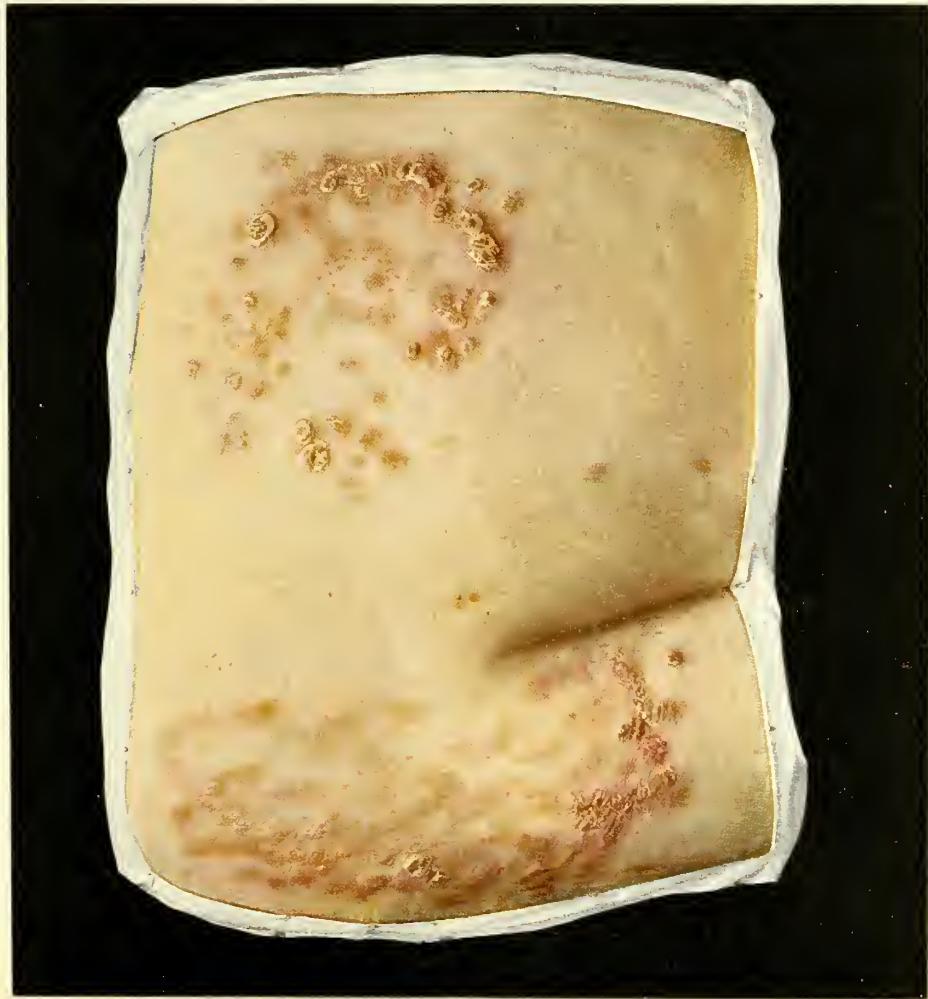
222. Syphilis gummosa glandis (Chancre redux).



221. Syphilis corymbiformis.



224. *Syphilis ulcero-serpiginosa.*



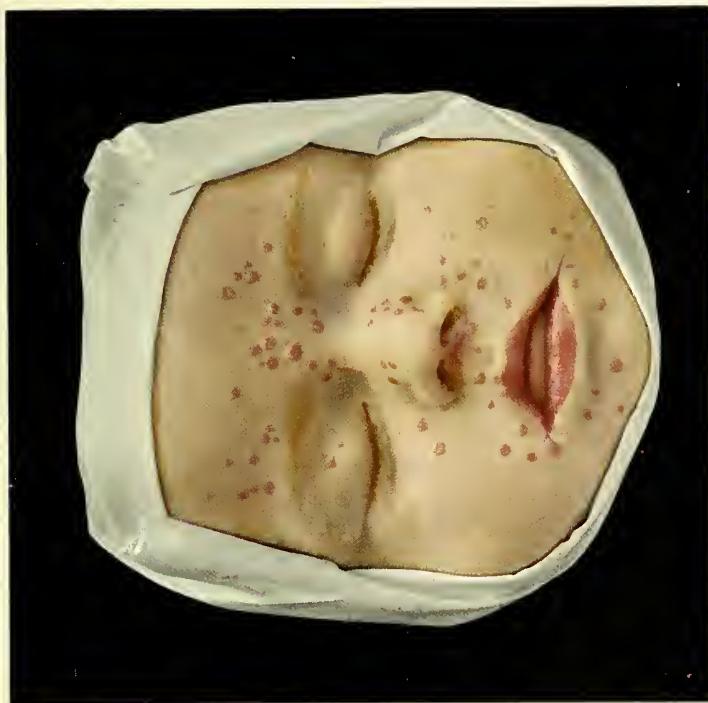
223. *Syphilis tubero-serpiginosa.*



226. *Caries syphilitica ossium cranii.*



225. *Cicatrices palati mollis post ulcerationes syphiliticas.*



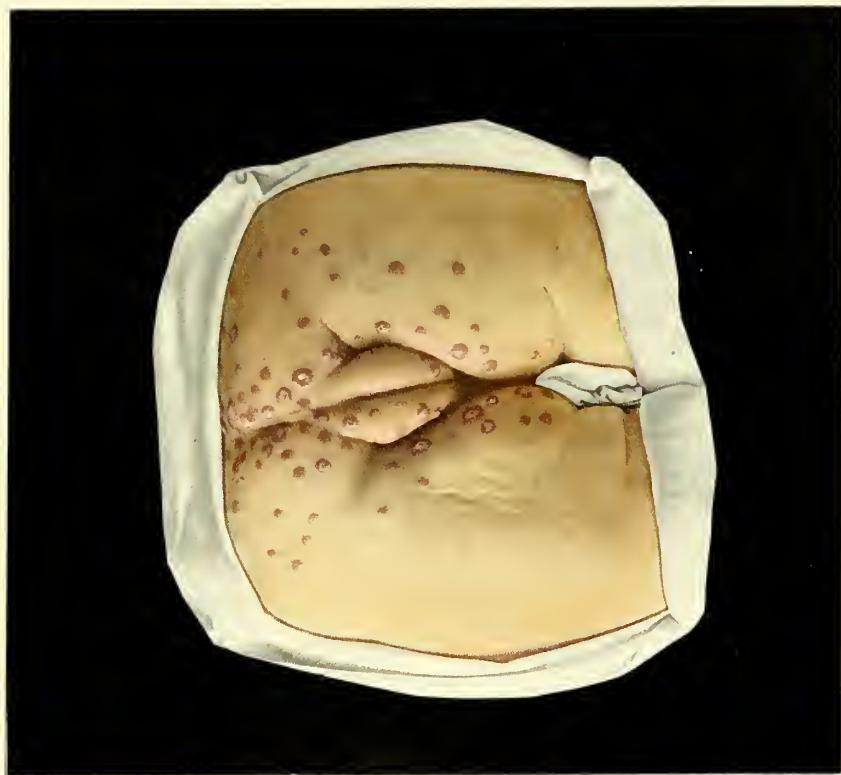
228. Syphilis hereditaria papulosa.



229. Syphilis hereditaria dentium (Hutchinson).



227. Syphilis hereditaria bullosa.



230. 231. Syphilis hereditaria papulosa.



Fig. 221. Model in Werther's Department in Friedrichstadt Hospital in Dresden (Kolbow).

Fig. 222. Model in Saint Louis Hospital in Paris, No. 1917 (Baretta). Fournier's case.

Fig. 223. Model in Freiburg Dermatological Clinic (Johnsen).

Fig. 224. Model in Freiburg Dermatological Clinic (Johnsen).

Fig. 225. Model in Saint Louis Hospital in Paris, No. 371 (Jumelin). Fournier's Collection.

Fig. 226. Model in Pospelow's Clinic in Moscow (Fiweisky).

Fig. 227. Model in Schlossmann's Infant Home in Dresden (Kolbow).

Fig. 228. Model in Schlossmann's Infant Home in Dresden (Kolbow).

Fig. 229. Model in Greef's Eye Clinic in Berlin (Kolbow). The illustration represents the teeth in the upper jaw.

Fig. 230. Model in Neisser's Clinic in Breslau (Kröner).

Fig. 231. Model in Schlossmann's Infant Home in Dresden.

Ulcus Molle Digiti.

Soft Chancre on the Finger.

SUPPLEMENT, PLATE XL., FIG. 232.

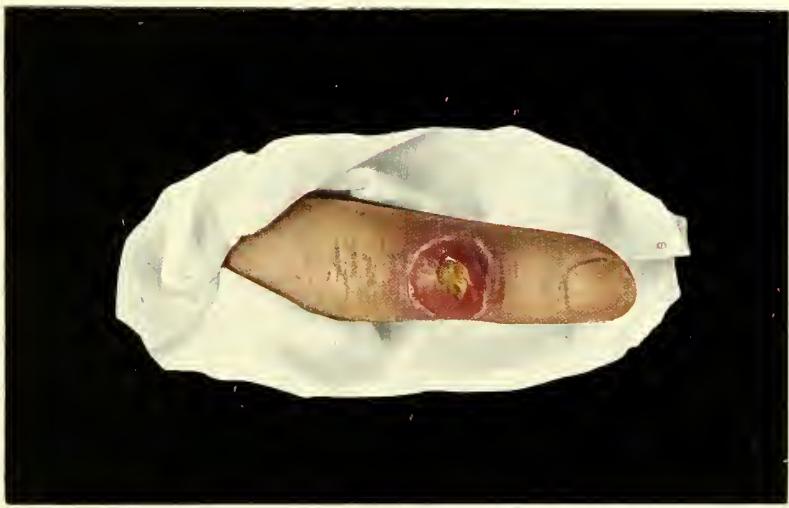
For Text, see Vol. II., page 167 *et seq.*

Fig. 232. Model in Jullien's Department in Hospital Saint Lazare in Paris (Jumelin). A very typical soft chancre on the right index finger; several similar chancre were present on the vulva of the same patient.

233. Ulcus molle orificii urethrae.



232. Ulcus molle digiti.





Ulcus Molle Orificii Urethræ.

SUPPLEMENT, PLATE XL., FIG. 233

For Text, see Vol. II., page 167 *et seq.*

Fig. 233. Model in Cochin Hospital in Paris, No. 384 (Jumelin).
Heurteloup's case.

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